Iowa Department of Human Services

Offer #401-HHS-003: Medical Assistance, Contracts, IowaCare and HIPP

Contact Information: Jennifer H. Vermeer, Jvermee@dhs.state.ia.us. (515) 725-1121

This offer is for:		This offer includes the following appropriations:
X	Status quo existing activity	Medical Assistance, Medical Contracts, IowaCare, HIPP, General Administration, Field Operations

Result(s) Addressed:

- Improve Iowans' Health
  - All Iowans Have Access to Quality Care including:
    - Preventive Care
    - Primary Care
    - Acute/Emergency Care
    - Long Term Care

Program Description:

This offer includes the Medicaid program and the administrative costs necessary to administer the program and deliver the health care benefits. Medicaid covers a comprehensive range of health care services for Iowans who meet the program's eligibility criteria. The services are delivered through private hospitals, pharmacies, physicians, nursing facilities, and other health care providers located throughout the state.

The key characteristics of the program are the following:

- Medicaid is a federal program operated by the state. It is an entitlement program under Title XIX of the Social Security Act. That means that the state must cover services to all those found eligible and may not arbitrarily reduce the amount, duration or scope of services.
- The program is financed with state and federal matching funds. Federal funds finance over 63% of the Medicaid program in Iowa in typical years. The federal match rate is over 70% at the present time due to the Federal American Reinvestment and Recovery Act (ARRA).
- Medicaid eligibility is based on a combination of income and other criteria that must be met. Generally, Medicaid covers low income individuals who are aged (over age 65), blind, or disabled, pregnant women, children (under 21 years of age), or members of a family with dependent children.
- Medicaid covers a comprehensive package of acute care services (hospital, pharmacy, physician, etc.) as well as long-term care services (nursing facility, institutional care, and home and community based services) for individuals who are disabled.

All states operate Medicaid programs. While each state's program is different in how expansive their eligibility or service coverage is, or the degree to which they have managed care organizations in their programs, all of the programs are very similar and face similar issues. For example, when the economy worsens, and unemployment increases, more people become eligible for and access the Medicaid program to cover their health needs. This has been true in Iowa, where enrollment increased by almost 8% in SFY 2009. In all states, Medicaid programs are a significant part of the health care delivery system. The Iowa Medicaid program is the third largest health care payer in Iowa, following Wellmark and Medicare. The program will serve over 559,000 Iowans, or 18% of the Iowa population in SFY 2011.

Total Medicaid expenditures (state, county and federal) in SFY 2011 will be over $3.75 billion. This $3.75 billion will fund payments for medical services to over 38,000 health care providers statewide. Payments are made to physicians, hospitals, labs, pharmacies, home health providers, rural health providers, federally qualified health centers (FQHCs), nursing facilities, chiropractors, physical therapists, home care providers, and many other types of providers. The impact of Medicaid on any individual provider varies by the type of service the provider delivers, and the population they serve. For example, Medicaid makes up between 10-20% of most hospital revenues, but is, on average, only about 50% of nursing facility revenue. In the area of services for the disabled (such as Intermediate Care Facilities for the Mentally Retarded – ICF/MR), Medicaid is often the primary or only revenue source.

The program's Federal match brings in over $2.3 billion in Federal dollars into the State. In order to draw the Federal funds, that state must fund the required State Match. The State matching funds consist of:

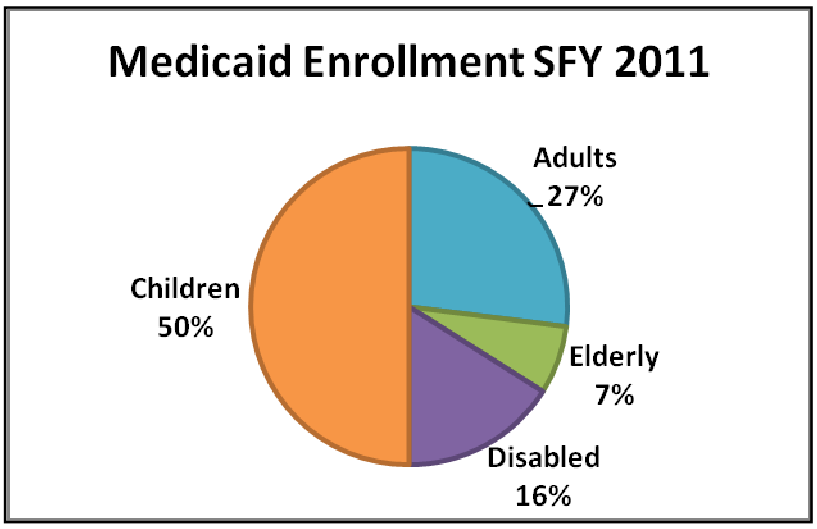
- $834 million from the State General Fund
- $112 million from the Health Care Trust Fund (revenue from the tobacco tax)
- $17 million from the Senior Living Trust Fund (revenue from General Fund ending balance)
- $55 million from other funds including the IowaCare Fund, Property Tax Relief, Pharmaceutical Settlement Fund Account, and the Health Care Transformation Account
- $42 million from the State Resource Centers
- $179 million from county/local funds. In Iowa, counties pay for the non-Federal Medicaid match for certain services for adults with chronic mental illness or intellectual disabilities. Other appropriations within the DHS budget are made to the counties that can be used to offset their Medicaid match costs.
- $210 million from other revenues such as recoveries and drug rebates.

Medicaid is an entitlement program, so states primarily control expenditures by either changing the eligibility requirements, the services covered, or the reimbursement rates to providers. Medicaid program expenditures grow each year, just as costs in the private health care system. Medicaid expenditures grow even more quickly during recessions or economic downturns when more individuals become eligible for and access the program. The expenditure growth is largely due to growth in enrollment – the average increase in the cost per person has been 1.4% for the past nine years. Expenditures are also driven by the cost of long-term care. Nearly half of the Medicaid budget is dedicated to institutional and community based services for elderly and disabled populations that need help with activities of daily living.

Who:

The Department of Human Services estimates that the Medicaid program will have more than 559,000 individual Iowans enrolled over the course of SFY 2011. As noted above, Medicaid will provide health care coverage for over 18% of Iowa's population at some point during a year. The Medicaid population consists of four general categories and is projected to serve the following in FY 2011:

- 276,077 children
- 152,943 low-income parents and adults
- 89,201 persons with disabilities
- 41,006 elderly persons



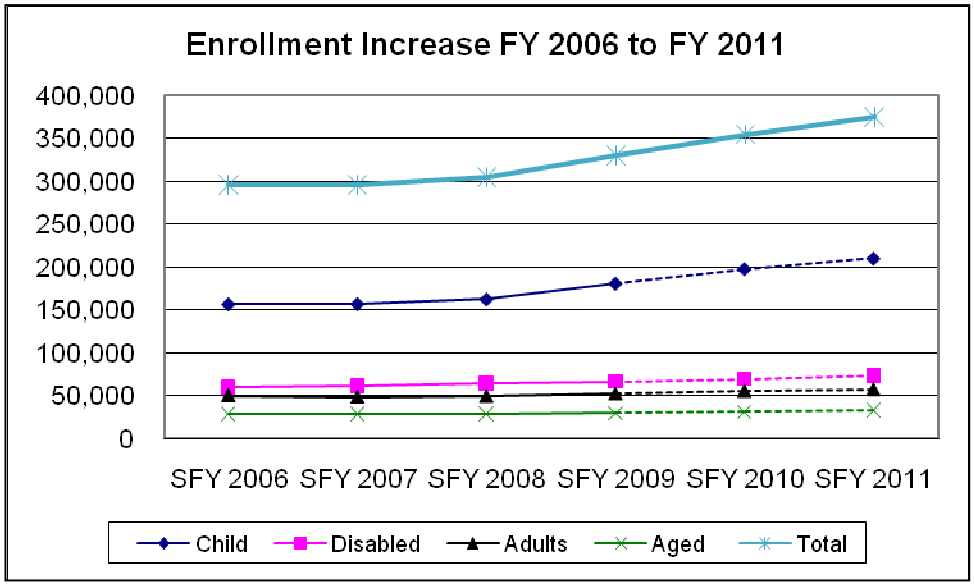
In order to be eligible for Medicaid, individuals must not only be low-income, they must also fall into one of the federally mandated categories: they must be children, frail elderly, disabled persons, pregnant women, or very low-income parents. This leaves many single persons and couples without dependent children ineligible for Medicaid, even if they have no income.

There are several eligibility groups within Medicaid (included in the figures above) that receive a different level of benefits than the 'full-benefit' Medicaid program. These groups typically have higher income and the benefits are targeted to specific populations. These eligibility groups may have premium requirements and more limited benefits.

- QMB - For persons who are Qualified Medicare Beneficiaries (QMB), Medicaid covers only the cost of Medicare premiums, deductibles, and co-payments.
- IowaCare – The program is an 1115 demonstration waiver and covers persons who do not fit one of the Medicaid 'categories' with incomes below 200% of the Federal Poverty Level. The covered services are limited to inpatient and outpatient hospital services, physician services, and limited dental and transportation services. Members have access to only two providers, the University of Iowa Hospitals and Clinics in Iowa City, and Broadlawns Hospital in Des Moines. In SFY 2011, the IowaCare program is expected to cover 51,262 adults.
- Family Planning Waiver – The program is also an 1115 waiver and covers women who don't qualify for the regular Medicaid program, up to 200% of the Federal Poverty Level. Women in the Family Planning Waiver receive only family planning services. A projected 31,334 women will receive these services in SFY 2011.

Overall enrollment in Medicaid has been increasing each year since 1996. Enrollment growth increased significantly in SFY 2009. Enrollment for parents and the elderly has remained stable, and there has been a small increase for the disabled. The largest growth since 1996, and in SFY 2009 particularly, is children. Since the beginning of SFY 2009, Medicaid enrollment increased by 32,356

individuals -- children accounted for 81% of this growth. The following table shows actual and projected enrollment growth for each category since SFY 2006.



The large growth in children is due both to the economic downturn, as families have lost access to health insurance due to employers dropping health coverage, unaffordable premiums, or loss of a job; as well as State policy efforts to expand coverage for children. Iowa policymakers have established a goal of covering all uninsured eligible children. Specifically, the department was to cover more than 25,000 children in three years. To accomplish this goal, the Iowa General Assembly and the Governor enacted a series of initiatives in 2009 (SF 389) designed to expand coverage and increase enrollment in Medicaid. These include:

- Expanding eligibility to 300% of the Federal Poverty Level effective July 1, 2009. Note: in the Medicaid program this only applied to infants less than one year of age; the remainder of the expansion occurred in the ***hawk-i*** program (see ***hawk-i*** offer for more detail).
- Presumptive Eligibility – this change will allow children to receive services during the time their formal application is being processed. It will also allow families to initiate enrollment through qualified entities which include medical providers and other community organizations, rather than only through the local DHS office. This change will begin January 1, 2010.
- Increased public awareness campaigns about Medicaid to encourage families to apply.
- SF 389 also directs the department to implement other policies to streamline application and enrollment processes.

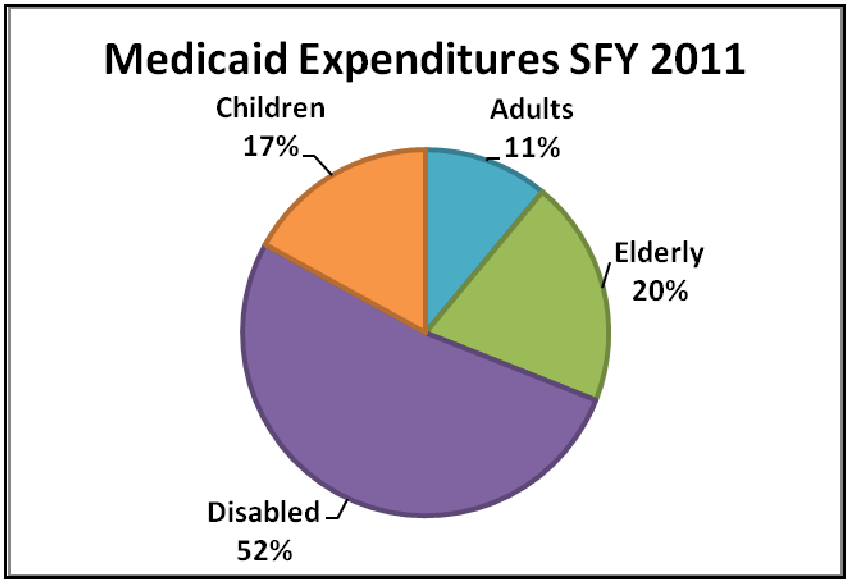
In 2009, 27,838 previously uninsured children were enrolled under one of these options. This exceeds the Department's SFY 2009 enrollment goal of covering an additional 20,980 children.

What:

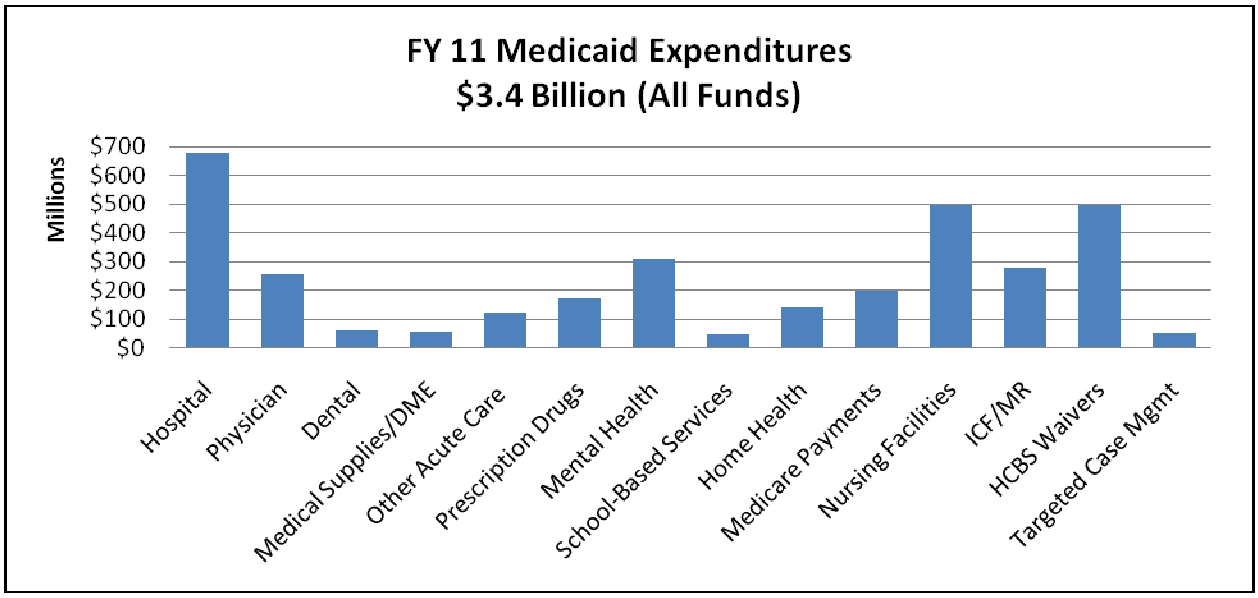
Iowa Medicaid pays for medically necessary health care services, including acute care services typically covered by any health insurance program. These include hospitalization, physician and advanced registered nurse practitioner (ARNP) services, dental care, emergency transportation by ambulance, laboratory, x-ray, and other services. The Medicaid program has a panel of more than

38,000 dedicated providers including hospitals, physicians, dentists, pharmacies, medical equipment providers, and many other health care providers of all types.

In addition, Medicaid provides coverage for long-term care services, such as nursing home care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community based care that allows individuals to stay in their own homes or other small congregate settings. Long-term care services provided at home, such as home health, assistance with personal care, homemaking, and respite care allow individuals to avoid or delay institutional care.



The cost of medical care for different Medicaid populations varies significantly. The average cost for each child in Medicaid is much lower than the average cost for each disabled or elderly person, since elderly and disabled individuals utilize more long-term care services. As shown in the charts above, although children make up 50% of the Medicaid population, they account for only 17% of total expenditures. This difference is true nationally as well. As noted above, there are a number of smaller programs within Medicaid that cover only a subset of the full-benefit package.



The table above reflects Medicaid provider payments across major service categories. In addition, this offer includes other transfers and administrative costs that total $3.75 billion dollars. Acute care expenditures account for approximately $2.1 billion in expenditures, while long term care (the last 4 categories on the right) account for $1.3 billion.

How:

Medicaid pays for Medicaid covered services to eligible members, by enrolled Medicaid providers. The reimbursement methods vary across provider types. Medicaid is the 'payor of last resort', and as such, has reimbursement rates that are often lower than private insurance or Medicare. For providers who serve almost exclusively Medicaid members (i.e. long term care providers) the rates are based on the cost of service.

Medicaid, as a payor of health care services, has all of the same responsibilities as any third party payor. The administration for the program is known as the Iowa Medicaid Enterprise (IME). The core business functions of operating the program include the following:

- Processing and paying claims submitted by providers for services delivered to members. Medicaid pays over 20 million claims per year. The average time from receipt of the claim to payment is less than seven days.
- Medical management functions are performed by medical professionals and include prior authorization of certain services to ensure the service is medically necessary, ensuring members meet the 'level of care' requirements to receive long term care services, disease management programs, quality assurance, and review of utilization to ensure the program is cost effective in the services provided.
- Provider network management, including contracting with providers, provider services call center and training, and reimbursement analysis and rate setting.
- Member services call center.
- Cost avoidance and recovery when other insurance is present, from estates, insurance settlements and drug rebates (Medicaid collects over $165 million in revenue to offset state and Federal costs).

- Pharmacy management and claims payment. IME operates a Preferred Drug List that saves the state over $30 million annually.

Iowa has undertaken innovative approaches to managing these programs and improving the quality of services. Iowa seeks to not simply be a payor of health services, but to manage high quality and cost-effective health care. The Iowa Medicaid Enterprise operates the Medicaid and IowaCare programs by integrating "best in breed" private contractors to efficiently process medical claims, work with providers and members, and aggressively pursue cost recovery. Provider satisfaction surveys show satisfaction has increased since implementation of the IME. Average wait time for a provider to talk to a call center representative is less than twenty seconds.

Medicaid will also pay the premiums for private insurance if cost effective (called the Health Insurance Premium Payment Program (HIPP). Other strategies include disease management programs, smoking cessation coverage, an electronic health record, preventive medical exams, Medicaid Value Management (MVM) to identify areas needed to target management strategies, multi-state drug purchasing pool, Preferred Drug List, and premiums.

The Medicaid program also has responsibility for contracting with other agencies, such as the Department of Inspections and Appeals for survey and certification of providers, such as nursing facilities and Intermediate Care Facilities for the Mentally Retarded, and with the Department of Public health for various health education and care coordination programs for children.

Service Delivery
Iowans access the program by submitting an application through the local DHS field offices. Local field staff determine eligibility for the program. This offer includes funding for 463.63 FTEs located in the local county offices (located in all 99 counties) who determine eligibility for the program, and manage the on-going cancellations and redeterminations that are required at least annually for the over 500,000 members on the program. Note that funding for eligibility workers has not kept pace with growing enrollment, so each year workers are managing more and more cases. This increased workload impacts performance and increases the error rate, as individuals are either made eligible or ineligible in error. Error rates are audited regularly by the federal government.

Once eligible, the covered health services are available through any of the 38,000 enrolled Medicaid providers. Medicaid pays providers for the services delivered.

Service Support
The Medicaid program is administered by the Iowa Medicaid Enterprise (IME). The IME is made up of 28 state FTEs managing nine performance based contracts with private vendors. The state FTEs perform the policy function and management of the vendors. The vendors carry out the majority of the business functions of operating the program. State and contract staff are co-located in a single facility to ensure integration of the vendor operations with the program management. The funding for the state staff is included in the "General Administration" appropriation, and all Medicaid contracts are funded from the "Medical Contracts" appropriation.

The offer funds 28 state FTEs with direct Medicaid administration responsibilities, as well 93.5 FTEs for all other administrative functions such as budget and accounting, information technology, personnel, etc. Staff are directly responsible for providing program oversight and support through the following functions:

- Overall Departmental oversight
- Program Support – policy development, administrative rules, provider and employee manual, Medicaid State Plan, Iowa Code
- Member and Provider Relations – appeals, exceptions to policy
- Communication – State/Federal relations, legislative requests
- Legal Support via the Iowa Attorney General's Office
- Information Technology – maintenance of existing systems and development of new and/or enhanced systems to improve efficiencies and customer service
- Financial Accountability – budget, accounting, federal/state reporting, cost allocation, audit coordination and resolution
- Contract Management/Purchase of Services
- Postage – distribution of provider payments
- Responsible for compliance and administration of the Medicaid program

American Recovery and Reinvestment Act Impact
ARRA authorized an estimated $87 billion in additional federal funding for States, in the form of a temporary 6.2 percentage increase in the funds the Federal government contributes toward Medicaid and Title IV-E programs. The increased match rate will be available for 27 months between October 1, 2008 and December 31, 2010. An increase in the Federal Matching Assistance Percentage (FMAP) formula offsets state dollars needed to fund the Medicaid program. These dollars have helped to avoid major reductions in Medicaid and other DHS programs during the recession period.

In SFY 2010, Iowa's FMAP rate is expected to be 71.34% as a result of the FMAP increases authorized through the ARRA; without this legislation, the FMAP rate would have been 63.29%. The increase is due to the across the board FMAP adjustment (6.2%) as well as an adjustment based on each state's unemployment rate (1.85%). This higher FMAP rate is expected to increase Federal participation by $179 million in SFY 2010. This results in state spending of $179 million less than it otherwise would have been without ARRA.

The increased FMAP rate expires on December 31, 2010 and only in effect for six months of SFY 2011. Additionally, the State is not expected to qualify for the unemployment adjustment in SFY 2011. As a result, state spending in SFY 2011 is expected to be only $65 million less than it otherwise would have been without ARRA. Although ARRA savings are still being realized, the net impact when compared to SFY 2010 is a reduction in savings of $114 million ($179 million - $65 million).

In addition, the state Medicaid appropriation received $8.6 million in SFY 2010 from ARRA Government Stabilization dollars in order to fund nursing facility rebasing and to continue to expand coverage for children. These dollars also end in SFY 2011, and will need to be replaced with state funds.

As a result, the state Medicaid appropriation needs to replace a total of $122.6 million ($114 million + $8.6 million) in ARRA dollars that were available in SFY 2010, but will no longer be available in SFY 2011.

Offer Description:

Today's Activities and Results:

The offer maintains the current eligibility levels and covered services for recipients of Medicaid and IowaCare. The offer addresses projected growth in enrollment in the program due to economic conditions, as well as changes in utilization patterns and costs. The offer assumes a continuation of current statute and regulation.

In addition to the changes discussed below, IME will implement a number of additional strategies during FY 2010 that will reduce Medicaid costs. They include:

- Correct Coding Initiative, which is a strategy to review all Medicaid claims for coding errors that result in overpayments. This initiative has been implemented by Medicare and many other payors with success in identifying errors and reducing costs. It is estimated to save $1,000,000 in state funds in FY 2010 for a partial year, and $2,500,000 in SFY 2011.
- Prior authorization of non-emergency high-cost imaging services, such as MRI, CT, and PET scans. Radiology was identified through analysis of services with high increases in cost and utilization. Prior authorization of these services is a common practice by private payors to ensure services are medically necessary. This will not apply to emergency situations. The estimated savings in SFY 2010 is $478,104 for a partial year and the estimated savings for SFY 2011 is $1,143,946.
- Data mining and predictive modeling. 2008 legislation requires IME to competitively procure data mining and predictive modeling services to analyze Medicaid claims and look for patterns of overutilization, fraud and abuse in the system. This service will be implemented during FY 2010 and is expected to result in savings; however, sufficient information is not available at this time to estimate the amount.

In total, this offer results in a decrease in General Fund support from the adjusted status quo level (excluding the ARRA federal dollar replacement amounts) of $10,383,306 for SFY 2011. The detail for the decrease is as follows:

- ($10,462,722) for a net decrease in the Medical Assistance program. This has historically been an increase, but normal growth has been offset by a projected year-end surplus for SFY 2010 that will carry forward into SFY 2011. Further detail behind this decrease is provided below:
    - $20,476,732 for growth in the utilization of fee-for-service (such as hospital, physician, laboratory, etc.) and inflation in cost-based reimbursement.
    - $17,081,466 for enrollment growth of 5.72% over SFY 2010.
    - $8,569,859 for increases in Medicare-related payments. This includes growth in the payment of Medicare Part A and Part B premiums, the Medicare Part D clawback payment, and payments for Qualified Medicare Beneficiaries (QMBs).
    - $7,493,897 for growth in mental health-related services. This is primarily due to increases in the number of persons covered by the managed mental health and substance abuse plan, known as the Iowa Plan. Persons over age 65 will begin being covered under this managed care plan 7/1/2010. Additionally, the growth in remedial services has contributed to the increase. Previously, these services were only available to children in the child welfare system, but now are available to all

children eligible for Medicaid. Increases are also projected for habilitation services and services provided in Psychiatric Medical Institutions for Children (PMIC's).
- $4,690,185 for home and community based waivers, due to enrollment increases in the Elderly Waiver and utilization/inflation increases in all waivers.
- $2,966,961 for increases in all other Medical Assistance programs. Increased enrollment/costs for Money Follows the Person, Targeted Case Management, Non-Emergency Medicaid Transportation (NEMT) and the Program of All-Inclusive Care for the Elderly (PACE) make up the majority of this increase.
- $1,833,333 to restore a one-time transfer from the Iowa Veteran's Home that is included in the SFY 2010 budget.
- ($16,023,601) for decreases related to program reductions and increased offsets. This includes a decrease in nursing facility payments due to a decline in bed days. It also includes projected increases in drug rebates and other recoveries, reductions due to one-time SFY 2010 payments that aren't expected to re-occur in SFY 2011, a reduction in State funding due to a projected increase in the regular FMAP rate, and an increase in the Property Tax Relief Fund transfer to the statutory level of $6.6 million.
- ($57,551,553) for a decrease related to the projected SFY 2010 carry-forward.

- In addition, the funding level includes $609,208 for Medical Contracts due to inflationary increases required per the contracts, operational costs, and information technology increases, Federally mandated activities and systems changes including Health Insurance Portability and Accountability Act (HIPAA) version 5010, electronic attachments, and Medicaid Management Information System (MMIS) vendor procurement. This includes a $190,555 savings by eliminating paper checks, remittance advices, and informational letters to providers, which will be converted to electronic methods of distribution and phased in during SFY 2010.

- A decrease of $609,208 to fund all necessary increases in Medical Contracts from the Pharmaceutical Settlement Account.

- $67,225 for Health Insurance Premium Payment (HIPP) administrative costs due to additional funding needed to meet staff and support costs estimated for SFY 2010. No increase in staff costs are assumed for SFY 2011.

- $12,191 due to postage increases.

Offer Justification:

Legal Requirements:

Title XIX of the Social Security Act authorizes and stipulates the requirements for the Medicaid program. These requirements are further detailed in the Code of Federal Regulations beginning at 42 CFR 440. The Federal regulations require any state that operates a Medicaid program to include, at a minimum, specific services for individuals who fit into defined categories. Federal regulations at 42 CFR 440.210 and 42 CFR 440.220 require that inpatient and outpatient hospital, physician, lab and x-ray, nursing facility, physician services, nurse midwife and nurse practitioner services must be provided. In addition, this requirement indicates attention to care for pregnant women. Further, the

Iowa Code also defines the services and eligibility categories the Iowa Medicaid Program is required to cover. This offer maintains our statutorily required services and populations.

Rationale:

All Iowans have access to Quality Care

In addition to the mandatory services described above, Iowa has elected to provide a myriad of optional services, which complement and expand quality of care ultimately delivered to its most vulnerable citizens. These include pharmacy, chiropractic, ambulance and dental services, among others described in this offer. Covering these optional services not only avoids more expensive medical interventions, it ensures that the 559,000 Iowans covered by Medicaid receive high quality, comprehensive health care services.

The offer will:

- Provide low-income children, adults (including parents), the disabled, the elderly and pregnant women with timely access to appropriate quality medical care.
- Bring over $2.3 billion dollars into Iowa from the Federal government in SFY 2011. To assess the full impact of these dollars on jobs and income and State tax revenues, one should also take into account the "multiplier" effect of these Federal dollars. There are numerous Iowa communities where Medicaid is the largest third party payor for medical service providers who are key players in the local economy.
- Maintain the administrative infrastructure necessary to support a performance based, evidence driven system of quality acute, preventive and long-term care services.
- Help shift the balance from institutional long-term care to community based long-term care and from long-term care generally, to healthy aging, by building a more informed membership.

Results:

Result:	SFY 2009 Actual Level	SFY 2010 Projected Level	SFY 2011 Offer Level
Percentage of State long-term care resources devoted to home and community based care. Medicaid strives to assure that members are receiving services in their communities whenever possible. The funds spent for all long-term care is compared to those spent for community services.	25.67%	26.67%	28.71%
Proportion of 15-month-old children with 6 well-child visits.	42%**	48%	48%
Proportion of children with an annual dental visit.	85%**	85%	85%
Proportion of persons with asthma where appropriate medications are used.	74%	83%	86%

Proportion of women receiving prenatal care from the first trimester.	66%**	72.5%	75%
State savings from pharmacy cost saving strategies, including PDL.	$29.3M (PDL) $8.8M (SMAC)	$30.5M (PDL) $7.1M (SMAC)	$27.8M (PDL) $7.1 (SMAC)
Savings from utilization and care management strategies. The Medical Services Unit reviews requests for prior authorization to determine medical necessity and recommend alternatives. Medical Services provides care management for members with high utilization and chronic conditions. Data on utilization are used to develop a savings over what would have been spent without such oversight.	$7 million	$8 million	$8 million
Savings from Surveillance and Utilization Review compared to contract cost. This dedicated unit used nationally accepted standards to search the claims database and find instances where payments may have been made incorrectly. The amount of overpayment recoveries is set by the contract with the entity performing this function.	432%	350%	350%

Result:	**SFY 2009 Actual Level**	**SFY 2010 Projected Level**	**SFY 2011 Offer Level**
Increase over the prior year in revenue collections from third parties. The collections (including cost avoidance measures) for SFY 2008 were 39.33% higher than the goal. Overall, the enhancement of the goal from year to year as specified in this contract would appear sound. The contracted performance measure is 15%.	13%	15%	15%
% increase in member satisfaction with administration of Medicaid program over prior year, based on survey results	5%	5%	3%

A 2006 survey set the baseline measure. Over the life of the Member Services contract the IME expects the positive rate to increase by 5% each year.			
% of members aware of Member Services A survey is performed annually by the PPC. The 2007 study indicated that 43% were aware of the helpline. A more recent survey (2008) has been performed but results are still being tabulated. The increase is an optimistic but achievable demonstration of the effort to make members aware of this helpline.	55%	60%	63%
% increase in provider satisfaction with the Provider Services Unit over prior year, based on survey results The overall performance score for provider satisfaction in 2008 was 3.76. The improvement for 2009 was a 5.01% increase. The goal of 5% per year in incremental improvement is appropriate.	5.01%	5%	5%

Result:	**SFY 2009 Actual Level**	**SFY 2010 Projected Level**	**SFY2010 Offer Level**
% of receipt days where clean claims are accurately paid or denied on time as per federal regulations. The Federal requirement is for 90% of clean claims to be paid in 30 days and 99% in 90 days. The IME currently shows that the average payment delay for a clean claim is less than 10 days.	99.9%	100%	100%

* Healthcare Effectiveness Data and Information Set (HEDIS) measures are used to describe these results and are gathered by the University of Iowa Public Policy Center (PPC) annually. These are compared with national standards and benchmarks. HEDIS data reports are currently only available for SFY 2008. Actual HEDIS data cannot be utilized until claims data has been finalized and that is generally determined by the PPC at 24 months following the fiscal year. The SFY 2011 and subsequent year goals are taken from the PPC report and recommendations for future year goals.

** Projected amount for SFY 2009.

Sustaining service delivery assumes the level of funding requested in the offer as well as full funding of salary adjustment. If salary adjustment is not received for SFY 2011, this would be the equivalent of the loss of an estimated 7.70 General Admin FTEs and 21.42 field FTEs. If funding is insufficient in either area, results to be achieved will be modified to reflect the impact.